Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Muiríosa Foundation
Centre ID:	OSV-0003959
Centre county:	Westmeath
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Muiríosa Foundation
Provider Nominee:	Brendan Broderick
Lead inspector:	Jillian Connolly
Support inspector(s):	Paul Pearson
Type of inspection	Unannounced
Number of residents on the date of inspection:	10
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
29 January 2015 10:30	29 January 2015 17:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

A registration inspection was conducted in July 2014 following an application by the Muiriosa Foundation to register the centre under the Health Act 2007. Twenty nine failings were identified with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Twenty three of which were the responsibility of the registered provider and six of which were the responsibility of the person in charge. The provider submitted an action plan in response to the failings identified. The purpose of this inspection was for inspectors to confirm if the actions had been taken.

The application submitted by the provider was for the centre to provide residential services to ten individuals both male and female. The centre had full occupancy on the day of inspection. In the main, inspectors identified that improvements had been made since the inspection in July 2014. However, not all of the actions had been satisfactorily completed. Twelve Outcomes were inspected on this inspection. Compliance was identified in four outcomes, communication, the written agreements between residents and the provider, safeguarding and safety and staffing.

Substantial Compliance was identified with the Statement of Purpose and the governance arrangements. Moderate non compliance was identified in the following five outcomes:

- Residents' Rights, Dignity and Consultation
- Social Care Needs
- Safe and Suitable Premises
- Health and Safety and Risk Management
- Records and Documentation

Major non -compliance was identified in respect of medication management and inspectors requested that the provider complete an internal review following on from the findings of inspectors which are detailed in Outcome 12.

Twelve breaches of regulation were identified on this inspection, eight of which are the statutory responsibility of the registered provider and four are the responsibility of the person in charge.

The action plan at the end of this report identifies the failings and the actions the provider/person in charge is required to take to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There were five breaches of regulation identified in this Outcome from the findings of the registration inspection which took place in July 2014. They pertained to the following:

- An absence of consultation with residents and their representatives
- Personal Information of residents being stored in an unsecured location
- The toilets and bathrooms did not promote the dignity of residents
- Free access to the designated centre from the outside
- Access to resident's money being restricted to office hours
- Negative outcomes for some residents based on the needs of others
- Complaints not being documented

Inspectors reviewed the actions identified by the provider in the action plan and confirmed that in the main the actions had been completed however further improvement was required to achieve compliance with regulation. For example, inspectors confirmed that the majority of personal information remained stored in the office within the centre, however this door remained locked and the keys were in the possession of the staff nurse on duty. Inspectors identified that a risk was present with this system as at times the staff nurse may not be present in the centre due to lunch breaks or supporting residents to access activities within the wider campus. Medication was also stored within this office. Therefore the keys were not readily available to access medication as required in the event of a resident requiring same immediately, such as in the event of a seizure. This is further discussed in Outcome 7. Inspectors did

find some personal information of residents including their record of sleep and diet and fluid intake located in a communal corridor and readily accessible for all. Therefore this action is repeated in the action plan at the end of the report.

Inspectors confirmed that electronic keypads had been installed on all entrances to the designated centre. There had also been alterations to the toilets as each cubicle had been converted into an enclosed room with a toilet and sink, with privacy locks. However whilst privacy signs was present on the toilet doors as stated by the provider, they remained absent from the shower room and bathroom. Therefore the occupancy of same was unclear.

Inspectors confirmed that the amount of money residents had access to had increased outside of office hours as stated in the response by the provider. However inspectors found that the policy regarding residents' finances had not been updated to reflect the change in practice, as it was dated March 2013.

Inspectors found that additional resources had been allocated to support residents following assessments being conducted by the appropriate Allied Health Professional. This had improved the quality of lives of residents as the needs of some residents were no longer negatively impacting on the quality of lives of other residents.

There was a policy in place regarding the management of complaints. The information regarding the complaints process was maintained in an accessible location in the designated centre. The details of any complaints made were maintained in a secure location. Inspectors reviewed the complaints recorded since the last inspection and found that whilst the policy had been adhered to and complaints had been processed in line with policy and regulations, the nature of one complaint evidenced that improvement was required to ensure that residents and their family were consulted as opposed to informed regarding the operation of the designated centre. This was identified as a deficit on the last inspection.

Records reviewed regarding a complaint demonstrated that decisions regarding the discharge of residents were decided at a multi- disciplinary level and family were consulted following this decision being made. This is further discussed in Outcome 5.

Judgment:
Substantially Compliant

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Of the sample of the individual personal plans reviewed, inspectors confirmed that residents had been re assessed by the Appropriate Allied Health Professional since the last inspection. Inspectors further found that guidelines were in place regarding the communication needs of residents. The policy in place for communication with residents had also been updated since the last inspection and was dated September 2014.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors reviewed a sample of the written agreements between residents and/or their representative and the service provider as required by Regulation 24(3). Of the sample reviewed inspectors confirmed that the agreements outlined the fees to be paid and the services that are received for the fee.

Judgment:
Compliant

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There were two failings identified in July 2014. The first pertained to assessments not identifying the actual supports residents required. Of the sample of plans reviewed, on this inspection, inspectors determined that whilst the supports required by residents were documented, the information did not consistently inform of the actual needs of residents. For example, for one resident the supports required for taking a shower differed from the manual handling supports documented.

Inspectors also found that whilst in the main, personal plans for residents were being reviewed annually, for one resident their pain assessment had not been reviewed in seventeen months. The resident was prescribed and administered pain relief on a long term basis.

A recurrent theme arising on this inspection and the previous inspection was deficits in the process regarding residents being admitted and discharged from the designated centre. In July 2014, the inspector found that the policy regarding the admissions, discharge and transition of residents was generic and did not inform of the actual criteria required for admission and discharge from the designated centre. Inspectors found that the policy had not been reviewed following that inspection. On this inspection practice was identified which had resulted in negative outcomes for residents. For example, as stated in Outcome 1, there was documented evidence of dissatisfaction of family members due to the absence of consultation regarding the potential discharge of a resident. The policy did not inform of the standard operating procedure in respect of this. Furthermore, there was inadequate assessment completed for a resident who had been admitted to the designated centre two weeks prior to the inspection to assess the actual supports the resident would require within the designated centre. For example, the resident had a history of weight loss however the appropriate assessment had not been completed. The weight of the resident had been recorded two weeks post admission. The policy did not guide of the practices of staff to support the admission of a resident.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The designated centre is a unit within a larger campus. Since the last inspection, the second designated centre within the building has ceased operation. Therefore, as of the day of inspection the centre shared a building with two day services. Due to the number of residents and the location, the centre is deemed a congregated centre. However the provider informed the inspector that admissions have been ceased and that there is a plan to de commission the centre within the current registration cycle of three years, as recommended by national policy. Whilst this is in keeping with best practice, on the previous inspection, inspectors identified that significant work was required in order for compliance with regulation to be achieved in the interim. Four failings were identified with regulation, they consisted of:

- There were numerous areas of the designated centre in disrepair
- The dining room was of an inadequate size
- Ventilation in an area for storage of cleaning equipment was inadequate
- There was an absence of suitable and sufficient cooking facilities
- The toilets were not suitable to meet the needs of residents
- The laundry facilities were located in the sluice room

Improvements had been made as the centre had been re decorated and areas of flaking paint had been repaired. Ventilation had been installed in the storage area and sluicing facilities had been removed from the laundry area. As stated in Outcome 1, the toilet cubicles had been converted to individual rooms. Whilst efforts had been made to address the inadequate space in the dining room, inspectors determined that it was still too small to provide adequate facilities for ten residents. A control measure implemented was to provide two sittings for dinner and unnecessary equipment was removed from the room. However the room remained non -compliant with the requirements of Schedule 6. There had also been efforts made to provide cooking facilities for residents, however this was outside the designated centre, as the kitchen/dining room was not of an adequate size. Therefore non - compliance with Schedule 6 remained.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
An action arising from the previous inspection was that the inspectors had identified hazards within the designated centre, which had not been identified in the risk register. Inspectors reviewed the risk register and identified that improvements had been made and that hazards previously identified had been included. There was also clear dates to

instruct staff on the date of review. On this inspection, inspectors found additional hazards in practice which were not documented in the risk register. As stated in Outcome 12, there were significant deficits identified in the management of medication. The hazards associated with storing and administering controlled drugs had not been identified. Therefore there were no concomitant control measures documented. This deficit was apparent in practice. There was also a risk present in respect of staff holding keys to the office as stated in Outcome 1. Environmentally, inspectors found that the water in the hand basin of the storage room for cleaning chemicals and equipment was too hot for effective washing of hands. There was also an absence of hand towels. However as this was not recognised as a hazard in the risk register, the control measures had not been identified or implemented in practice.

This deficit is directly linked with a previous failing of inadequate hand hygiene practices. Inspectors reviewed records and confirmed that all staff had received hand hygiene training since the last inspection. There was also evidence that the person in charge had commenced auditing of hand hygiene practices. However as the absence of adequate hand hygiene facilities for staff completing house hold duties had not been identified, this reduced the effectiveness of the audit completed.

Evidence on the previous inspection did not support that residents could be evacuated at night in the event of an emergency. Since the last inspection, the designated centre had conducted a fire drill and had increased staffing to two staff at night as opposed to one. However inspectors determined that improvements were still required as the evacuations did not demonstrate that residents could be evacuated horizontally within two and half minutes (which is best practice) to a safe location. The evacuations recorded the length of time that it would take to complete an evacuation of the entire building as opposed to demonstrating the effectiveness of the control measures such as the fire doors in place. All staff had received training in the prevention and management of fire since the last inspection.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
In July 2014, there was evidence that resident's lives were negatively impacted by the behaviours of other residents. Inspectors found on this inspection that the environment was in the main calm and relaxing, which resulted in residents presenting as content. Interventions had been implemented to proactively support residents who had a history of engaging with behaviours that challenge. These included:

- Regular reviews by members of the Multi - Disciplinary Team
- Review of the positive behaviour support plans of residents
- Increase in activation and occupation for residents
- Increase in staffing at night

There was a plan in place for one resident to be discharged from the centre due to unsuitability of the placement. However due to circumstances beyond the control of the provider, this could not occur within the time frame stated in the action plan submitted to the Authority. Inspectors were informed that an alternative residence was being sourced prior to a transition plan being created.

Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors reviewed the action taken following on from the last inspection, to ascertain if medication management procedures were safe and effective. Whilst the actions had been taken in respect of the administration of medication as stated in the action plan submitted by the provider, non-compliance remained, therefore the actions were ineffective. Inspectors identified a significant risk in the procedures regarding the accounting and administering of controlled drugs.

The organisation has a policy in place regarding the ordering, receipt, prescribing, storing, disposal and administration of medication. However there was no centre specific policy in place for the handling and administration of controlled drugs. The general policy references that immediately after the administration of medication the administrator must record the administration on the medication administration sheet. The policy further states that in the event that the medication administered is categorised as a controlled drug the registered nurse must also record the administration in the control drug register. Inspectors were informed at feedback that

the absence of any additional information in the policy regarding controlled drugs was as registered nurses must adhere to the guidance provided to nurses on medication management in July 2007 by An Bord Altranais. However inspectors determined that the guidance was not implemented in practice. On review of the control drug register, there were instances in which the monitoring/ checking of the stock balance at the commencement of each shift was signed by only one staff. Inspectors also observed that the entry for the evening stock check was pre-populated by one staff on the day of inspection. Controlled drugs were also recorded as being administered on one occasion in the control drug register however it had not been recorded in the resident's administration record. This is not in line with the An Bord Altranais guidelines and the organisation policy.

On review of the prescription of the resident, the medication was prescribed to be administered every seven days. Inspectors observed an instance in which there was an eight day period between administration. As stated in Outcome 5, the pain assessment for a resident had not been updated in an eighteen month period, therefore pain relief was being administered in the absence of a contemporary baseline being established.

Further deficits were identified in the administration records of residents, as inspectors observed that staff had documented administration of medication outside of the template columns. Therefore making it challenging to ascertain the exact date and time of administration.

Inspectors communicated the evidence to management during the course of the inspection and at the feedback meeting and requested that management complete an internal review of the management of controlled drugs for the previous six months. It was further requested that the findings of the review be submitted to the Chief Inspector once complete.

Judgment:
Non Compliant - Major

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors found in July 2014 that the Statement of Purpose was not reflective of the actual practices of the designated centre. Inspectors reviewed the Statement of Purpose which was present on the day of inspection and dated 26 January 2015. While a revision

had taken place as stated in the action plan, a further review was required to ensure that it was reflective of the criteria used for admission to the designated centre. The Statement of Purpose reviewed stated that access to the service was in accordance with the organisation's policy on Access, Discharge and Transfer which was dated 2013. However as stated in Outcome 5, inspectors determined that the policy was generic and did not inform of the actual criteria required for admission and discharge from the designated centre. Therefore the Statement of Purpose did not adequately outline the criteria used for admission to the designated centre. The Statement of Purpose also did not reference that admissions to the centre had ceased as inspectors were verbally informed.

Judgment:
Substantially Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Since the previous inspection, a notification had been submitted to the Authority for a change to the person in charge. The person in charge was formally interviewed on the 10 December 2014. The person in charge is a registered nurse and has responsibility for two designated centres. The person in charge demonstrated sufficient knowledge of their statutory responsibilities and had systems in place to ensure that they are in a position to meet them in both designated centres. The improvements identified on this inspection further evidenced that in the main the systems were effective. However based on the deficits identified in medication management and hand hygiene facilities on this inspection, inspectors determined that a review was required to the audits conducted in this area to ensure practices are safe.

Judgment:
Substantially Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and

recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There was an absence of staff supervision on the previous inspection. Inspectors found that as of the day of inspection, this had commenced. However, records did not support that all staff had received formal supervision. Improvements in the service and speaking to staff evidenced that there had been an increase in informal supervision since the last inspection. Staff stated that the person in charge is generally present in the designated centre for a portion of the day when they are on duty. The person in charge submitted to the Authority a schedule demonstrating that staff had received formal supervision and the dates for the remaining staff following the inspection.

As stated in Outcome 5, 7 and 8, there was also an increase in staffing at night and a review of staff during the day which had reduced risk and improved the quality of life of the residents, since July 2014.

Judgment:
Compliant

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
On this inspection, all the policies as required by Schedule 5 were present in the designated centre which was a failing identified in July 2014. However as stated in Outcome 5 and 13, the admissions policy and the policy regarding resident's finances was not reflective of the actual practices in the designated centre. The medication

management policy was not implemented in practice as evidenced in Outcome 12.

Inspectors found that the residents' guide was accurate and informed residents of the operations of the designated centre. The action relating to the records maintained for each drug and medicine administered to residents had not been satisfactorily completed as stated in Outcome 12.

The actions are repeated in the action plan at the end of this report.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Jillian Connolly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Muiríosa Foundation
Centre ID:	OSV-0003959
Date of Inspection:	29 January 2015
Date of response:	08 May 2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A resident and their representative had been informed regarding decisions about the future placement of a resident as opposed to consulted.

Action Required:
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

Please state the actions you have taken or are planning to take:
• Each individual will be supported to transition from the Designated Centre in consultation with the individual and their families. A transition plan has been developed and guides the staff team supporting the individual throughout the transition process and incorporates periodic review for one year post transition.
• The Regional Director and Area Director are scheduling meetings with the individual's families, to identify their wishes for the individual's future and explore transition planning.
• A consultation plan will be developed incorporating the views and wishes of the individual and family within the restraints that may exist in terms of staffing and suitable accommodation.
• The revised "Moving to New House-Principles of Support Version 2" document will be used to support and document the process. Date of implementation 21st April 2015

Proposed Timescale: 21/04/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal Information of residents was located a communal corridor.

Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
• Supervision meeting held with each individual staff member in relation to storage of recording charts and ensuring that such charts in use are stored appropriately. Supervision meetings with all staff commenced on 30th January 2015 and were completed on 28th April 2015.
• Discussion was held at staff team meeting on 24th February 2015 and item remains on agenda for each monthly staff team meeting.
• Staff inducted to Schedule 5 Policy on 24th February and 19th March 2015, Management of Service Users Files Standard Operating Procedure by the Local Manager, which clearly stipulates that all files pertaining to the individual must be stored securely.

Proposed Timescale: 28/04/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence did not support that a comprehensive assessment had been completed prior to a resident being admitted to the designated centre. Information was also inconsistent in the assessment for one resident.

Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
• A comprehensive assessment of the individuals needs has been undertaken by the staff team, commenced on 16th January 2015 and completed on 5th February 2015.
• At the PIC quarterly meeting with Regional Director and Area Director, the requirement for a comprehensive assessment to be undertaken with an individual as part of the transition plan was discussed on 1st May 2015.
• A supervision meeting was held with Local Management responsible for ensuring all required assessments are undertaken prior to admission on 30th January 2015
• An information session was held on 19th March 2015 with Local Management in relation to above regulation and Statutory Instruments.

Proposed Timescale: 01/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The pain assessment of one resident had not been reviewed annually to ascertain if the information remained relevant.

Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
• The pain assessment tool was reviewed on 3rd February 2015 and no changes in the management of the individuals pain control was required.
• A meeting in relation to the breach was held on 19th March 2015 with Local Management and the staff team in relation to the annual reviewing of assessment and more frequently if required.
• The oversight of the required annual review was also discussed separately with the individuals named nurse on 30th January 2015.

Proposed Timescale: 19/03/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence that residents were planned to be discharged from the designated centre contrary to the wishes of the resident and/or their family.

Action Required:
Under Regulation 25 (4) (d) you are required to: Ensure the discharge of residents from the designated centre is discussed, planned for and agreed with residents and, where appropriate, with residents' representatives.

Please state the actions you have taken or are planning to take:
• Each individual will be supported to transition from the Designated Centre in consultation with the individual and their families. A transition plan has been developed and guides the staff team supporting the individual throughout the transition process and incorporates periodic review for one year post transition.
• The Regional Director and Area Director are scheduling meetings with the individuals families, to identify their wishes for the individual's future and explore transition planning.
• A consultation plan will be developed incorporating the views and wishes of the individual and family within the restraints that may exist in terms of staffing and suitable accommodation.
• The revised "Moving to New House-Principles of Support Version 2" document was implemented on 21st April 2015 and will be used to support and document the process.

Proposed Timescale: 21/04/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The dining room was not of an adequate size.

Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
• A total of eight individuals utilise the dining room space. Two individuals do not use the room at meal times.
• Of the eight individuals who utilise the space, two individuals only use the dining room when it is vacant as their needs indicate a low stimuli environment to promote adequate dietary and fluid intake, as per the individuals care plan.
• Two sittings continue as dictated by the individual's needs and personal preferences.
• Four individuals are currently in the transition plan process and will no longer reside within the unit after July 2015. This will result in only four individuals requiring to use

the dining room.

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no kitchen area provided within the designated centre with suitable and sufficient cooking facilities.

Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
The kitchen area currently in use is within the same building as the designated centre. The kitchen which is fully equipped and meets HACCP standards is approximately 11.5 metres away from the main door of St. Agatha's (floor plan enclosed).
The kitchen is open and available exclusively to individuals residing in the designated centre, 24 hours per day, 7 days per week.
The designated centre is earmarked for closure with support from the funding body by end of 2016.

Proposed Timescale: 31/12/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The practices in relation to the administration of medication was inadequate, particularly in relation to controlled drugs.

Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
• An internal investigation has been undertaken and subsequent findings and action plan have been forwarded to the Chief Inspector on 15th April 2015.
• Incrementally the required actions as specified on the action plan have been implemented immediately following discovery of the error by the area director and person in charge.

Proposed Timescale: 29/01/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Statement of Purpose did not adequately state the criteria used for admission to the designated centre as required by Schedule 1.

Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
The Statement of Purpose and Function was reviewed on 30th January 2015 and submitted to the Authority on 6th March 2015.

Proposed Timescale: 06/03/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review was required in respect of the audit systems in place to ensure they are robust and effective.

Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
• Training will be undertaken on 14th May 2015 with the Nurse Team in relation to effective auditing by the Person in Charge.
• A monthly audit review tool was developed and has been in use since 1st March 2015 and the outcome of this is discussed at each monthly staff meeting.
• A spot check template was developed on 1st March 2015 and is discussed with the local manager and staff team at the monthly staff meeting.

Proposed Timescale: 14/05/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
Not all policies listed in Schedule 5 were reflective of the actual practices of the designated centre or implemented in practice.

Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
• The Standard Operating Procedure in relation to the Access, Discharge and Transfer of individuals to a new designated centre will be completed on 15th May 2015 and will be referenced in the revised Statement of Purpose and Function for designated centres.
• An addendum to the Communicating with Residents Policy was developed on 25th February 2015 outlining more specific procedures in the development of Communication Protocols for each individual.
• Deviation from the Medication Management Policy has been investigated internally and subsequent findings and action plan were forwarded to the Authority on 15th April 2015.

Proposed Timescale: 15/05/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records maintained in respect of residents were inadequate as required by Schedule 3.

Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
Assessment
• A comprehensive assessment of the individuals needs has been undertaken by staff team, commenced on 16th January 2015 and was completed by 16th February 2015.
• At the PIC quarterly meeting on 1st May 2015 with the Regional Director and Area Directors, the requirement for a comprehensive assessment to be undertaken with an individual as part of a transition plan was discussed.
• A supervision meeting was held with Local Management responsible for ensuring all required assessments are undertaken prior to an individual's admission to a new designated centre on 19th March 2015.
• An information session was held with Local Management in relation to above regulation and Statutory Instruments on 19th March 2015

Pain Assessment
• The pain assessment tool for the individual was reviewed on 3rd February 2015.
• An information session was held with Local Management in relation to annual

reviewing of assessment and more frequently if required on 19th March 2015.

Admissions & Transfer Policy within designated centres
• The Standard Operating Procedure in relation to the Access, Discharge and Transfer of individuals to a new designated centre will be completed on 15th May 2015 and will be referenced in the revised Statement of Purpose and Function for designated centres.

Proposed Timescale: 15/05/2015